Ageing well

A person-centred approach to later-life care

NHS

Lancashire and South Cumbria

Integrated Care Board

Frailty Training

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Why is frailty Important?

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- Frailty is a distinct clinical state which there is decline in multiple physiological systems, Increased vulnerability to minor external stressors. Frailty varies in its severity and individuals should not be labelled as being frail or not frail but simply that they have frailty. (BGS, 2018)

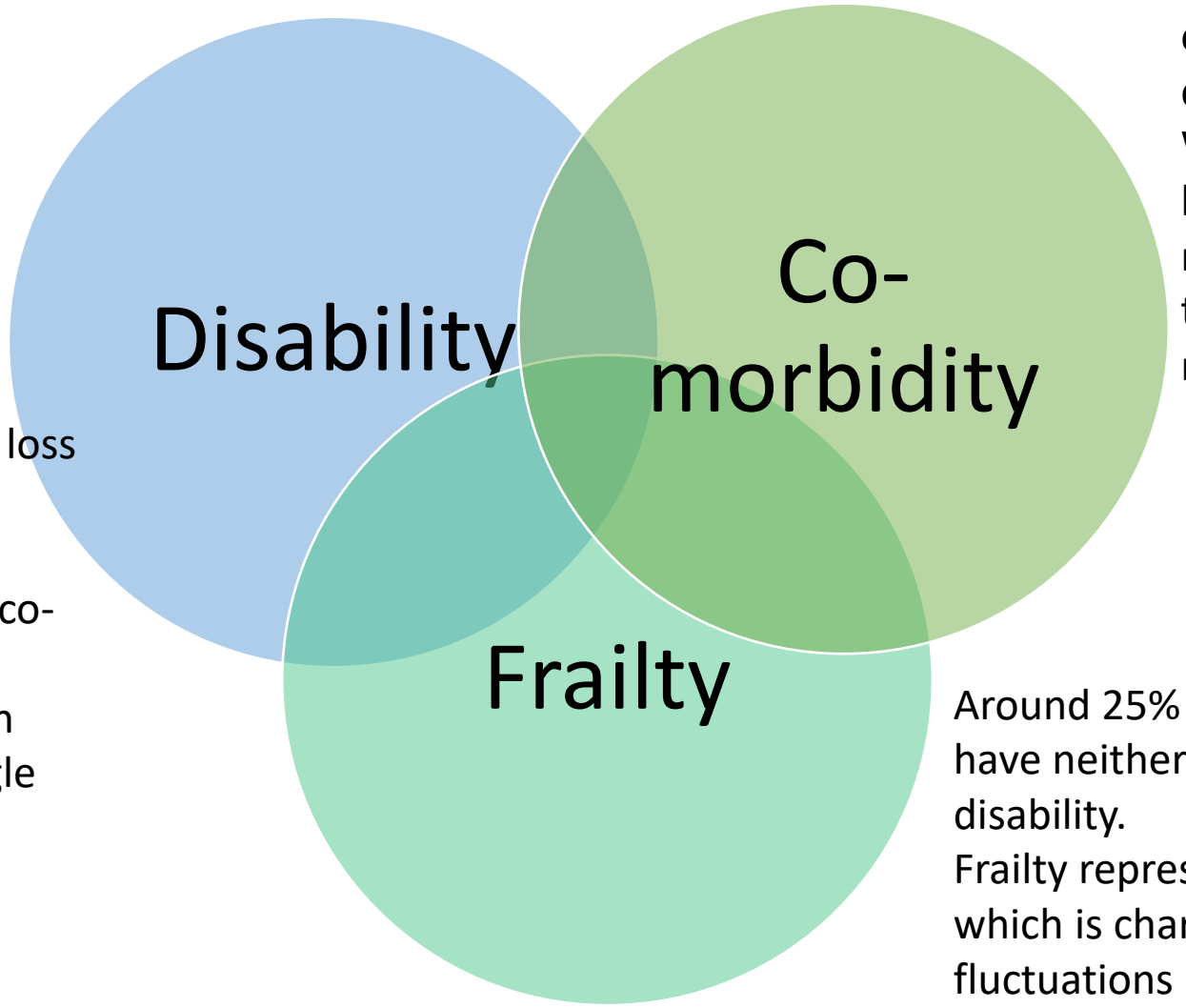
Frailty is a major cause of hospital admissions in the UK with 4000 admissions to Accident and Emergency per-day (NHS Rightcare, 2019).

50% of people over the age of 65 are living with some degree of frailty and ageing well is a priority for NHS England (Frailty Framework, 2018, Joining The Dots, 2023).

It is estimated that 1 in 5 are over 65 in Lancashire and South Cumbria (Midlands and Lancashire commissioning Support Unit 2023)

Frailty is a major cause of mortality an
morbidity worldwide (Solakoglu et al,

Prevalence and overlaps of co-morbidity, disability and frailty among community dwelling men and women 65 years +



Co-morbidity is the presence of 2 or more long term conditions (co-morbidity)
Whilst most people who have frailty have co-morbidity, the majority of those with multimorbidity do not fit the criteria for frailty

Disability is a physical or mental impairment that has substantial negative effects on ability to undertake normal activities
It is a static and stable functional loss
Around 50% of disability in older adults develops chronically and progressively in association with co-morbidity and frailty
The remaining 50% of disability in older adults develops after a single event such as stroke

Around 25% of older people with Frailty have neither multiple co-mor… disability.
Frailty represents a dyn…
which is characterised …
fluctuations in function…
It can be thought of as '…

Introduction

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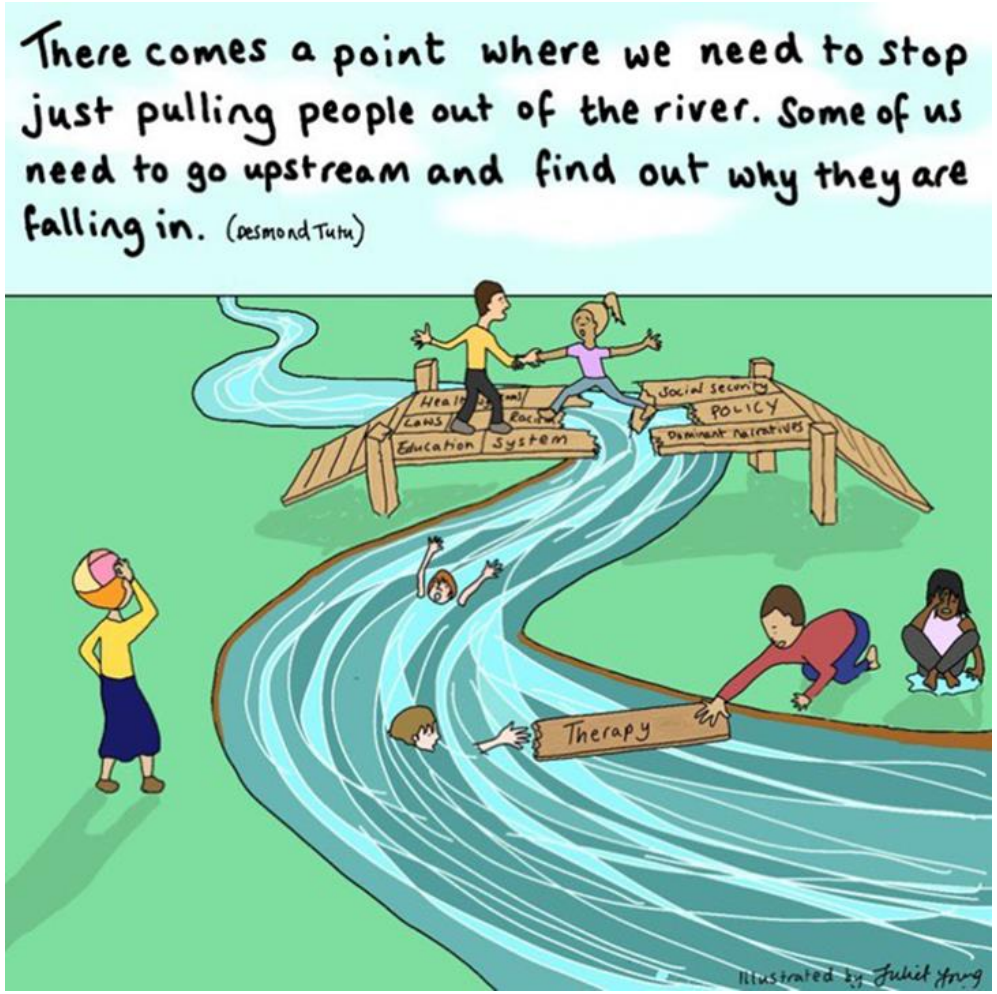

- Early identification of frailty can help support people to get access to the right care at the right time to enable them to live an independent and healthy life.
- Measurement of Frailty for 65+ - the Electronic frailty index (Efi) is a risk stratification tool and Clinical Frailty Scale (CFS) is a validated diagnostic tool.

What exactly is Frailty and how can it affect people?

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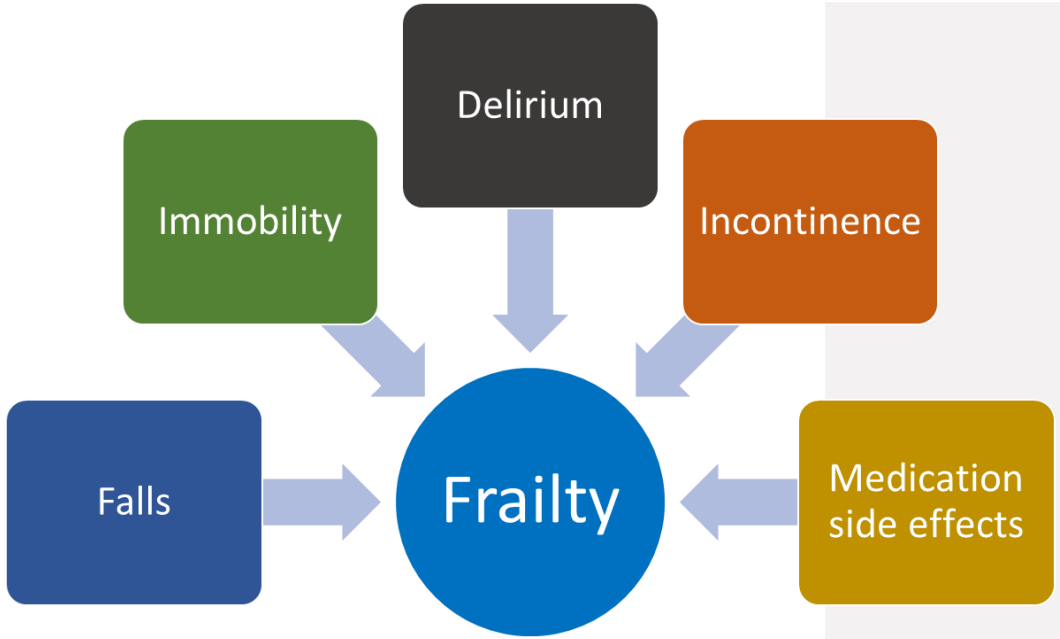

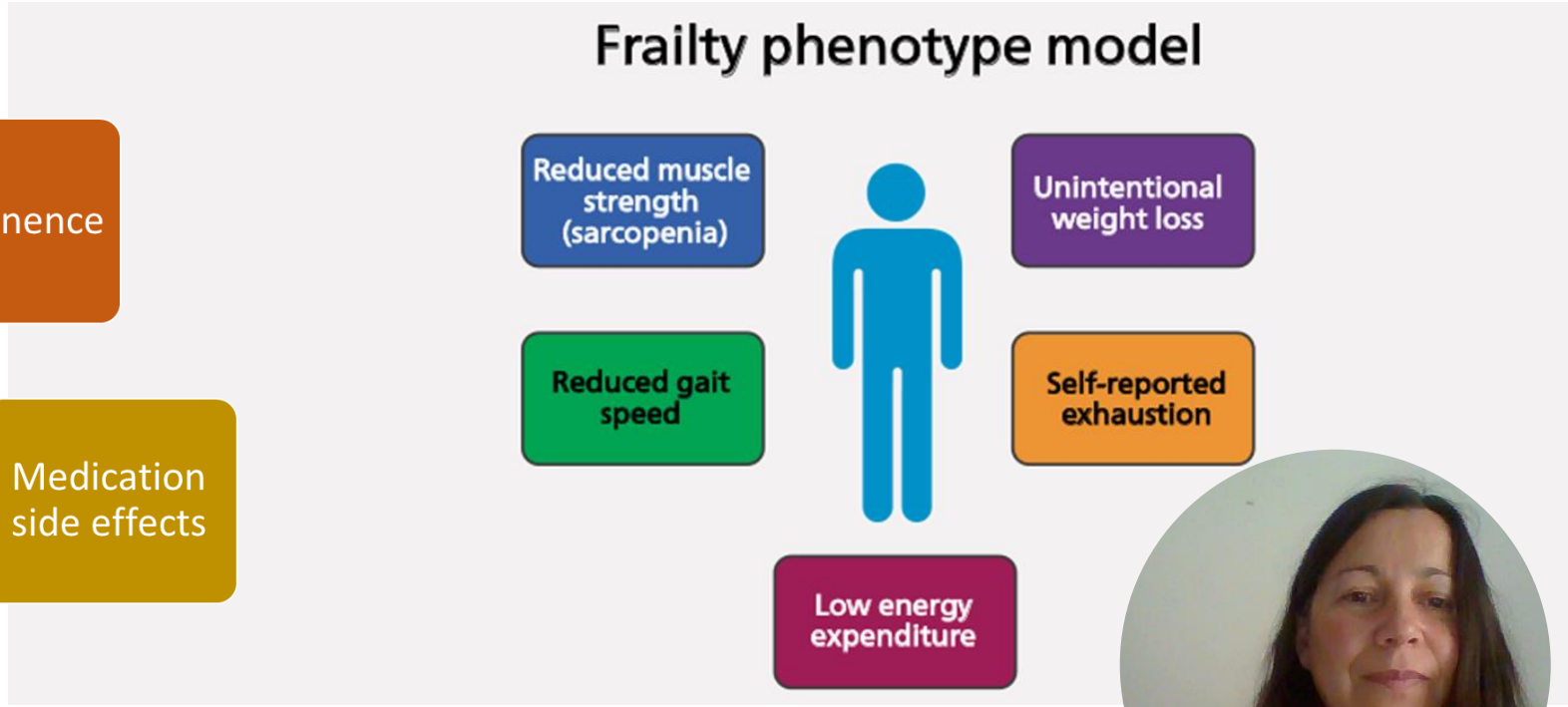

How do I Identify Frailty?

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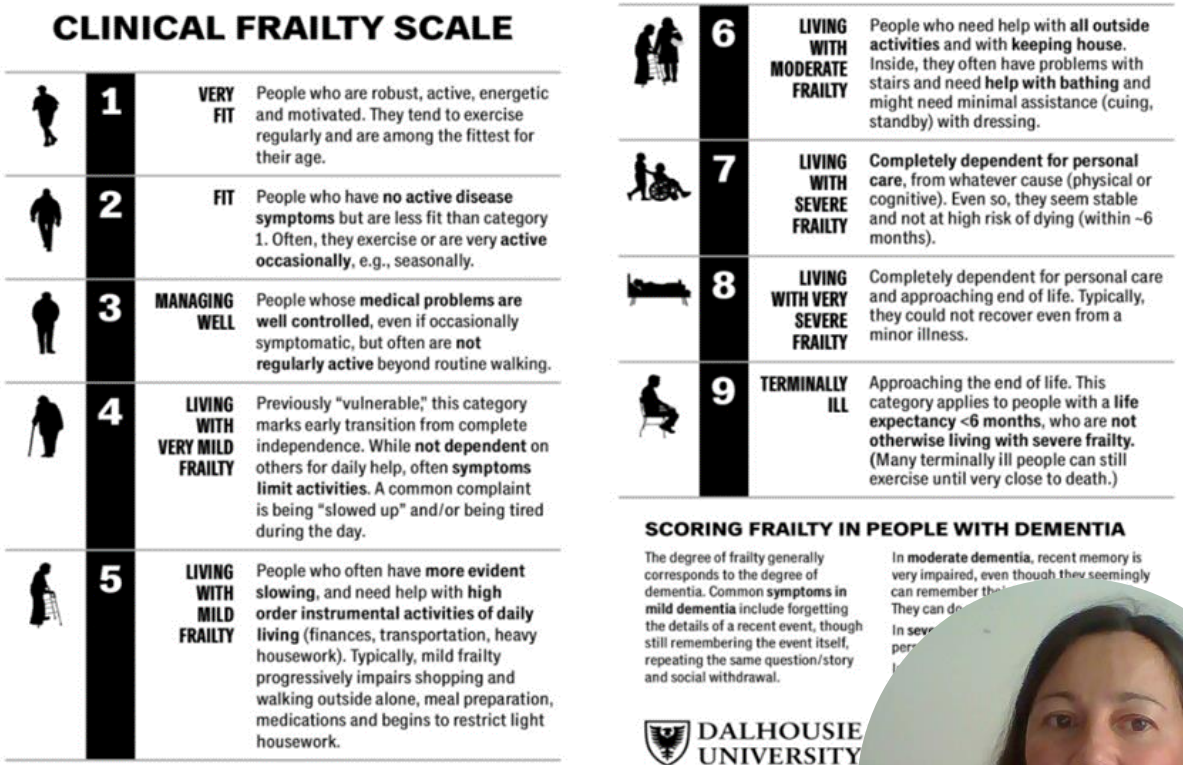
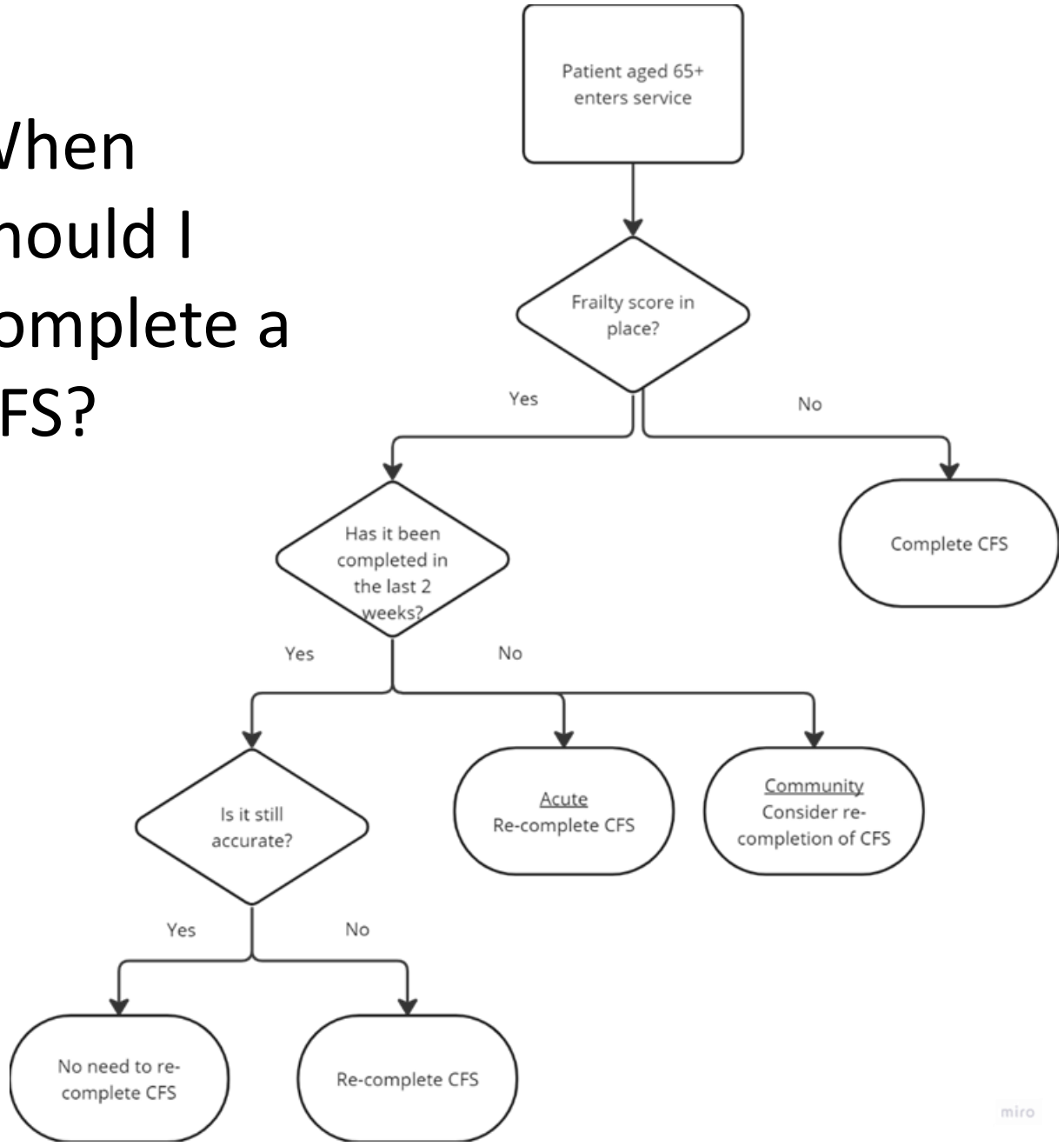
- The Clinical frailty scale is validated for use in all 65+ individuals. It can be completed quickly.
- Document on EMIS – use the code: 763 264 000 (GP practice) or start to type ‘Rock’ and the Rockwood CFS will come up or in the template being used
- It can be used by all healthcare professionals
- You need to assess normal functional level therefore, if someone is in hospital or acutely unwell assess their status from at least 2 weeks ago
- • You may need to check normal function with relatives or other healthcare professions – don’t just guess from the pictures on the CFS



When should I complete a CFS?



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- This flow diagram is on the Good practice guide
- It can help you identify when to complete and when to revisit the CFS

After Frailty has been identified- What do I do next?

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If a CFS score of 6 or greater is identifed it is recommended that they have a Comprehensive Geriatric Assessment

Please see the Good Practice Guide and Frailty Clinical Support tools to help guide your personalised care approach

Frailty – Clinical Support Tool East Lancs

efi	Clinical Frailty Scale (CFS) Score	Clinical Prompts / discussions	Possible Personalised Care Planning Approach
0.12 or less	3 – Managing well 	☐ Eye check ☐ Hearing check ☐ Annual medication review ☐ Annual Health check- LTC/>75 completed in the last 12 months ☐ Healthy lifestyle advice ☐ Exercise- local gym, social prescribers ☐ Employment advice for those still working ☐ Nutrition ☐ Social circumstances ☐ Advice on how to avoid disease trajectory	• Local activity groups to socialise – specialised groups e.g., Veterans in Community (VIC) • CVS newsletter/CVS - social prescribers / community website • Consider smoking cessation, drug, and alcohol support services • Local Gym- exercise classes - LCC / Age UK / CVS • Employment support, pensions advice • Consider referral to Fire service for environmental checks / smoke alarms • Consider MSK physiotherapy referral if required
0.13-0.24	4 –Living with very mild frailty 	☐ Eye check ☐ Hearing check ☐ Annual medication review ☐ Annual Health check- LTC/>75 completed in the last 12 months ☐ Cognition ☐ Mood ☐ Continence ☐ Nutrition ☐ Social circumstances / isolation ☐ Functional Independence ☐ Social support	• Local activity groups to socialise – specialised groups e.g. Veterans in Community (VIC) • CVS newsletter/CVS - social prescribers / [illegible] • Local exercise & balance classes - LC[illegible] • Strength & balance class via Inte[illegible] • Services to support at home- A[illegible] services / equipment) / Home[illegible] • Consider referral to Contine[illegible] • Consider MSK physio referra[illegible] (ITT) for holistic assessment • Consider referral to Fire serv[illegible] alarms

What is a comprehensive Geriatric Assessment?

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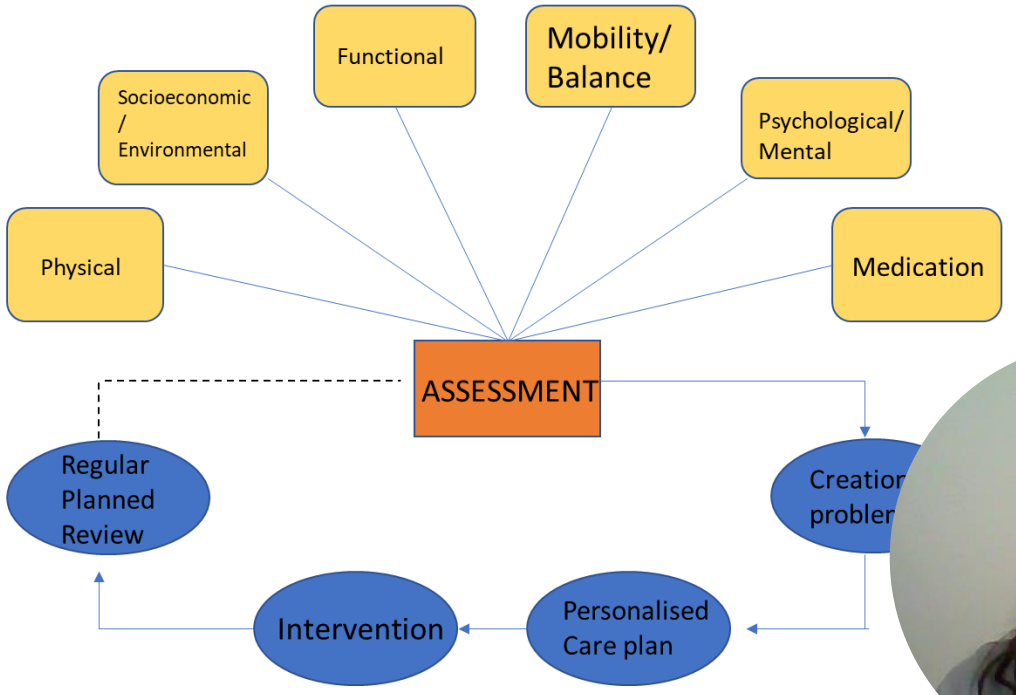
- **If a CFS score of 6 or more it is recommended that they have a Comprehensive Geriatric Assessment**

- **Gold standard care is Comprehensive Geriatric Assessment (CGA) and personalised care and support plans**

- **Consider onward referral to local specialist teams**
e.g. community rehab and Integrated Neighbourhood Teams

CGA- Widely recommended as the gold standard for assessment and management of frailty



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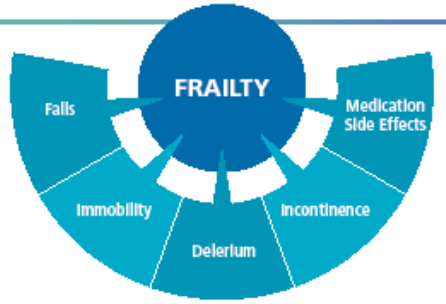
Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.



Identification: All over 65s in primary care

Electronic Frailty Index

Identification of any of the frailty syndromes (left), complete the CFS

Clinical Frailty Scale (CFS)

Personas and Clinical Frailty Scale

CFS 1
Very fit

Andy (in the Blue Vest) is 70 years young.
He took up marathon running when he retired at the age of 60.
He has planned well for his retirement and is living life to the full
Andy does not think age is a limitation and doesn't believe frailty is inevitable!

CFS 2
Fit

Sarah is 68.
Enjoys Pilates once per week. She's pretty fit other than the odd niggle.
She walks with her friends during the summer months but does much less in the winter
She would like to move to a warmer climate but has family close by who need her, so she keeps dreaming!

CFS 3
Managing well
Some reversible features

Masoud is 70.
He has COPD which is fairly well controlled.
He is sometimes anxious, especially since covid and is less sociable.
He gets out with his son monthly to do a longer walk but is not regularly active beyond routine walking.

CFS 4
Living with very mild frailty

Khaleda is 68.
She has arthritis, diabetes and high blood pressure. She is on multiple medications and chooses to take supplements in addition. She doesn't need any help with her activities of daily living but is starting to feel 'slowed up' and some days her symptoms limit her activity, particularly when the weather is bad and has a neighbour who helps occasionally in the snow and ice.

CFS 5
Living with mild frailty

Mohammed is 80.
He's been fit most of his life. He has Parkinson's disease and poor vision and uses frame and help of one person to mobilise. He goes to the mosque every Friday and for special occasions. In the summer he likes to sit outside and shake everyone's hands on the way in as he used to. He is an important person in his family and his wider community. People still go to him for advice.

CFS 6
Living with moderate frailty

Maureen is 75.
She has multiple health issues. She has had two new hips and has an artificial heart valve. Since her last hip replacement, she has carers 3x per day to help her with washing, dressing and meal preparations. The carers have noticed she needs more prompting with tasks and have advised she doesn't use the hob when they are not there.
She doesn't want to go into care.

CFS 7
Living with severe frailty

Doris is 93.
She lives in a care home, she has dementia and is now non-verbal. She needs help for all activities such as washing, dressing and uses a standing hoist to get from bed to chair. She doesn't have capacity. Whenever she is somewhere different, she becomes agitated. Family live down south and visit a few times per year, many of her friends and close relatives have now passed.

CFS 8
Living with very severe frailty

Bob is 90.
He has had a respiratory virus which has gone on his chest. His heart failure has made this worse and his recent stroke which has meant he is no longer mobile.
He has expressed his wishes and has an advanced care plan in place. He has had a visit from the ACP and the nursing home are giving him nebulizers and monitoring him.
He is not thought to be in the last six months of life.

CFS 9
Terminally ill

Allan is 89.
He is in the hospice for end of life care, his wife is elderly and can't manage him at home.
The hospice is providing all of his care. His wife is present much of the day.

No Frailty | **Mild Frailty** | **Moderate Frailty** | **Severe Frailty** | **Termin**

CFS 1–3 Prehab
Monitor. Advice – diet, nutrition, activity, MSK physio if needed

CFS 3–6 Rehab
Active rehab and management to reverse signs of frailty or prevent further deterioration

CFS 5–8 Enablement
Management of non-reversible features and enabling input to optimise function, participation and QOL

CFS 8–9 Palliative
Palliative care services, advan
care planning, DNAR, carer sup

Patient Education

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Summary

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- Frailty is a long-term condition that has the capability to take away a person's independence and health. Whilst it is common in older people, it is not an inevitability of ageing.
- Early identification of frailty can help support people to get access to the right care at the right time to enable them to live an independent and healthy life. There are a variety of tools used to identify frailty, we are asking you to use the Clinical Frailty Scale (CFS) on all patients 65+
- Once identified, a person with frailty can then be supported through a comprehensive geriatric assessment (CGA) which provides a ho multidisciplinary review to ensure all potential issues are supp

References and Useful documents

- British Geriatric Society (BGS) 2018 BGS website
- British Geriatric Society BGS toolkit for comprehensive geriatric assessment in primary care settings
- https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-08-23/CGA%20in%20Primary%20Care%20Settings.pdf
- British Geriatric Society 2023 joining the dots; A blueprint for preventing and managing frailty in older people
- https://www.bgs.org.uk/policy-and-media/joining-the-dots-a-blueprint-for-preventing-and-managing-frailty-in-older-people
- British Geriatric Society Comprehensive Geriatric Assessment (CGA) https://www.bgs.org.uk/cgatoolkit
- NHS RightCare: Frailty Toolkit 2019 NHS England https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf
- NICE 2016 Multimorbidity clinical assessment and management NG 56 https://www.nice.org.uk/guidance/ng56
- Frailty a framework of core capabilities 2018 Skills for Health https://www.skillsforhealth.org.uk/wp-content/uploads/2021/01/Frailty-framework.pdf
- NICE 2016 QS136 Transition between inpatient hospital settings and community or care home settings for adults with social care needs https://www.nice.org.uk/guidance/qs136
- Healthcare improvement Scotland reed codes guide
- https://ihub.scot/media/6442/20190705-efi-read-codes-guide-v10.pdf